ATTENDING PROVIDER TREATMENT PLAN

☐ INITIAL SUBMISSION ☐ FOLLOW-UP SUBMISSION

DATE SUBMITTED: Month | Day | Year

TYPE OR PRINT LEGIBLY

CLAIM #:

PATIENT INFORMATION

1. PATIENT'S NAME — Last / First / Initial
2. PATIENT'S ADDRESS (No. Street)
3. CITY
4. STATE
5. ZIP CODE
6. TELEPHONE # (Include Area Code)
7. PATIENT BIRTHDATE
8. SEX ☐ M ☐ F
9. INSURANCE COMPANY
10. POLICY NUMBER
11. DATE OF ACCIDENT
12. IS PATIENT'S CONDITION RELATED TO:
    A. EMPLOYMENT? ☐ YES ☐ NO
    B. AUTO ACCIDENT? ☐ YES ☐ NO
    C. OTHER ACCIDENT? ☐ YES ☐ NO
13. IS PATIENT UNABLE TO WORK? ☐ NO ☐ YES

POLICYHOLDER INFORMATION (if different)

14. POLICYHOLDER'S NAME — Last / First / Initial
15. POLICYHOLDER'S ADDRESS (No. Street)
16. CITY
17. STATE
18. TELEPHONE # (Include Area Code)
19. ZIP CODE
20. RELATIONSHIP TO PATIENT

PROVIDER INFORMATION

21. NAME OF TREATING PROVIDER — Last / First / Initial
22. TAX I.D.
23. NPI
24. SPECIALTY
25. FACILITY OR OFFICE NAME
26. FACILITY /OFFICE ADDRESS (No. Street)
27. CITY
28. STATE
29. ZIP CODE
30. TELEPHONE # (Include Area Code)
31. EMAIL ADDRESS
32.. FAX # (Include Area Code)
33. INITIAL DATE OF TX
34. DATE OF LAST VISIT

35. PATIENT MEDICAL HISTORY. HAS PATIENT EVER HAD ANY OF THE FOLLOWING SERVICES? CHECKMARK THOSE APPLICABLE BELOW. (*NOTE-ALL BOXES CHECKED REQUIRE A BRIEF DESCRIPTION OF SERVICE AND DATE PROVIDED ON SEPARATE ATTACHMENT)

☐ MEDICATIONS ☐ MRI ☐ SURGERY ☐ X-RAY ☐ DIAGNOSTIC TEST ☐ EXISTING CONDITIONS ☐ COMORBIDITIES ☐ OTHER

36. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below using Diagnosis Pointer in section 38 below) ICD Ind. ☐ 9 ☐ 10

A.	B.	C.	D.
E.	F.	G.	H.
I.	J.	K.	L.

37. CHECK APPROPRIATE CARE PATH (if applicable)

☐ CP1 ☐ CP2 ☐ CP3 ☐ CP4 ☐ CP5 ☐ CP6

PROPOSED COURSE OF TREATMENT AS IT RELATES TO THIS MVA

38. DATE(S) OF REQUEST FROM MM	DD	YY	TO MM	DD	YY	PROCEDURES, SERVICES OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	EQUIPMENT Purchase	Rental	SPINAL INJECTION Unilateral	Bilateral	DIAGNOSIS POINTER	FREQUENCY (Times per visit)	FREQUENCY (Visits per week)	DURATION (# of weeks)	TOTAL UNITS

☐ **INCLUDE SUPPORTING DOCUMENTS**

FRAUD PREVENTION - NEW JERSEY WARNING

ANY PERSON WHO KNOWINGLY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE OR MISLEADING INFORMATION IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

PROVIDER STATEMENT

I HAVE PERSONALLY COMPLETED AND PREVIEWED THIS FORM. THE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND BELIEF.

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SIGNATURE OF PROVIDER DATE